CSMS User Access Form

Please fax completed form to (954) 357-5986

REQUESTED ACTION: (Check One): Add ☐ Update ☐ Disable ☐

* **First Name:**		Middle Name:	
*** Last Name:**		Preferred Name:	
*** Email Address:**			
*** Telephone Number:**			
* **Agency Name:** (From the Resource Guide)			
***Location Name:** (From the Resource Guide)			

Additional Agency (ies)/Location(s)		

ROLE (check one): *** = Required**

Case Worker ☐ Supervisor ☐ Contract Admin ☐ (Broward County Staff Only)

Note: Supervisor is able to delete Activities or add Activities to close cases. Select this role if user is involved in the billing process, regardless of job title at Agency.

REQUIRED SIGNATURES: I hereby agree that I will only use this access for approved purposes only. I will not divulge or share access with anyone, I will promptly change my password if it has been compromised, and will notify my Information Security Officer of any security breach.

Applicant Signature: _____ Date: _____ Date Trained: _____

Administrator/Director Signature: _____ Date: _____ Trainer Signature _____

Administrator/Director Print Name: _____

User Confidentiality Security Agreement

I, the undersigned, have received and read a copy of the Broward County Human Services Department Information Systems User Security Principles and Policies as referenced in the training participant guide. I hereby agree to abide by these principles and policies.
I acknowledge that violations of the Principles and Policies may result in criminal prosecution, civil liability, civil penalty and may subject me to disciplinary action, including possible termination of employment.
I understand that the purpose of this agreement is to emphasize that all client information contained in any of the Human Services Department's client services systems is confidential.
I understand my professional responsibilities, and that I am to report suspected or known security violations to Broward County Human Services Department.
I understand that access to confidential information is governed by State and Federal laws. Client confidential information includes medical, social, and financial data.
Client data collected by interview, observation or review of documents must be in a setting which protects the client's privacy.
I further understand and acknowledge the following:

1. Registered user ID's and/or passwords are not to be disclosed.
2. Information, electronic or paper-based, is not to be obtained for my own or another person's personal use.
3. Client services information systems, data and information technology resources shall be used only for official business purposes.
4. Copyright law prohibits the unauthorized use or duplication of software.

User Print Name: _____ User Signature _____ Date: _____

Agency Name: _____ Supervisor Name: _____

********** **INTERNAL USE ONLY** **********

Approved (Administrator signature): _____

Assigned User ID: _____ **Agency** _____ **Location** _____

Assigned Group: _____ **Implemented By** _____

Date: _____ **Comments:** _____

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